

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/06/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/27/2005
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NAME OF PROVIDER OR SUPPLIER

LIFE CARE CENTER OF RENO

STREET ADDRESS, CITY, STATE, ZIP CODE
**445 W. HOLCOMB LANE
RENO, NV 89511**

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F 000	<p>INITIAL COMMENTS</p> <p>This Statement of Deficiencies was generated as the result of three complaint investigations conducted at your facility on 4/21/05. The investigations were on-going until 5/27/05.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>Complaint #NV00007985 was a self reported incident of a resident fall from bed. The incident was substantiated. No deficiencies were written based on the facility's investigation and actions.</p> <p>Complaint #NV00007879 was a self reported incident of a resident fall from bed. The incident was substantiated. No deficiencies were cited based on the facility's investigation and actions.</p> <p>Complaint #NV0007928 alleged that the facility neglected the care of a resident. The allegations were substantiated with deficiencies written at F 309 and F 281.</p>	F 000	<p>Without admitting or conceding either the existence, or the scope and severity, of any of the citations alleged on this statement of deficiencies, Life Care Center of Reno submits this plan of correction solely to comply with State and Federal regulations requiring such submission.</p> <p>This plan of correction is to serve as the credible letter of allegation for all deficiencies cited on this 2567. Life Care Center of Reno hereby alleges compliance with all requirements of participation as of the completion dates set forth in this plan of correction.</p>	
F 281 SS=G	<p>483.20(k)(3)(i) RESIDENT ASSESSMENT</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to provide services that</p>	F 281		

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TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 met professional standards of quality for one resident. Findings include: The findings for this deficiency are crossed referenced with F 309 CFR 483.25 Quality of Care. Resident #1: The resident was a 90 year old female that was admitted to the facility on 4/1/05. She was admitted from the acute care hospital, due to ulcers on the tips and underneath several toes on the left foot. She had other diagnoses which included cellulitis of the left lower extremities, atrial fibrillation with anticoagulant therapy, congestive heart failure, anemia, peripheral vascular disease, chronic obstructive pulmonary disease, hypothyroidism and intravenous antibiotic therapy due to the foot ulcers. Information gathered from The Lippincott Manual of Nursing Practice, Sixth edition, Copyright 1996, Lippincott-Raven Publishers states that Coumadin therapy is considered one type of anticoagulant therapy. The purpose of anticoagulation therapy is to disrupt the blood's natural clotting mechanism or, in other words, to increase the amount of time that it takes for blood to clot. The manual also states that nursing should be aware of the following with regard to sensitivity to Coumadin. One of the factors that may intensify the action of coumadin is antibiotic therapy. Resident #1 was on IV antibiotics for pressure ulcers on her toes on the left leg. The manual further states that the nursing should observe the resident carefully for any possible	F 281	F 281 I. Resident #1 has been discharged to an acute care hospital. Facility maintains that the staff provided services that met professional standards of quality for resident #1. II. Current residents receiving anticoagulation therapy will be reviewed to observe for excessive bleeding/bruising. III. Facility will educate nursing staff regarding: anticoagulation therapy and intensified effects when antibiotic therapy is combined; monitoring for excessive bleeding/bruising; skin tear prevention measure; close monitoring of PT/INR; and use of Coumadin Flowsheets. IV. Resident Care Managers to monitor 10% of residents on anticoagulant therapy for PT/INR completion and completion of thorough skin checks. Results to be submitted to QA committee quarterly. Corrective actions will be taken as needed.	7/8/05	7/8/05

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F 281	Continued From page 2 signs of bleeding and report immediately...and that nursing should inspect the skin carefully for any bruising. The patient is to be instructed that she should contact her health provider in case of an accident and that the patient should not participate in any activity in which there is a high risk of injury. As demonstrated by the finding in the cross referenced deficiency at F 309 and standards of nursing practice as written in the Lippincott Manual of Nursing Practice, the facility failed to provide services that met professional standard of quality by not monitoring and assessing the resident's injury to her left lower extremity.	F 281		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to ensure that each resident received and the facility provided the necessary care and services to attain or maintain the highest physical well-being of Resident #1. Findings include:	F 309		

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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2BYG11 Facility ID: NVN696S If continuation sheet Page 4 of 9

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F 309	Continued From page 4 Resident #1 was noted in the medical record to have very fragile skin. On 4/11/05, the resident fell sustaining a hematoma to the "top of head" area. No other injuries were noted on the nursing note documentation. On 4/14/05, at approximately 3:00 AM, Resident #1 was found on the floor in her room between the beds of her and her roommate. She was assessed and "assisted (back) into bed." The staff "cleaned laceration with 2 sm (small) S.T. (skin tears) L (left) lower leg with NS (normal saline), applied dressing. Other S.T. (skin tear) L (left) leg cleaned with NS steri strips applied and DRG (dressing) applied." On 4/14/05 the "weekly skin check /narrative work sheet" had documentation that stated that the resident had a skin tear to the back of the left leg with a dressing applied. There was no further description of the wound i.e. measurements, color, whether or not there was internal bleeding around the area due to the Coumadin therapy etc. The resident's condition worsened as the days passed. The main medical concern, per facility nursing and physician documentation was Resident #1's pulmonary condition. On 4/16/05, the resident was sent to the acute care hospital emergency room (ER) for evaluation and eventual admission into the hospital. In the ER Resident #1 was assessed with "shortness of breath with mild respiratory distress, mild temperature elevations (noted from long term care facility), rales and wheezes, diffuse ecchymosis (bruising), a big hematoma of the left calf with laceration, a superficial skin tear to the that aspect of the left calf and also lateral aspect	F 309	nurse's responsibility to provide care. A place will be provided on CNA flow sheet to document refusal of care. Should a resident refuse care, the licensed nurse shall provide resident education on the importance of care to be delivered and offer alternatives, document this education and alternatives offered, and if resident continues to refuse, the nurse shall document the continued refusal and refer to Social Services and Resident Care Manager. A care plan will be implemented. IV. Resident Care Managers to monitor 10% of residents on anticoagulant therapy to ensure that skin observation was completed. Results to be submitted to QA committee quarterly. Infection Control Coordinator to review residents on antibiotic therapy and report findings to QA committee quarterly. Resident Care Managers to review refusals as documented on 10% of CNA ADL flow sheets to determine follow through of refusal process. Report findings to QA committee quarterly. Corrective actions will be taken as needed.	7/8/05	

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F 309	Continued From page 5 of the left leg. There is skin denudation between the fourth and the fifth toes on the left. There was a superficial skin tear medial aspect of the right leg." The acute care facility took pictures of the wounds. A wound doctor was called in to look at the wounds. The hematoma, on the left calf, measured 10 cm by 9 cm and was covered with black necrotic tissue. The resident was followed by the wound doctor and on 4/23/05, the physician ordered physical therapy to do debridement. On this same day the a physician note that stated, "very difficult situation. [Patient] has rallied somewhat ...leg wound is extensive a deep intramuscular hematoma and large open surface. This will never heal as is without deep debridement and grafting-cont prognosis for healing and survival poor." The physician documented that Resident #1 might encounter bleeding problems, due to her Coumadin therapy that had caused elevated anticoagulant lab values, if extensive debridement and/or surgery was initiated. Bedside debridement of the area was done by physical therapy staff after the resident was given Vitamin K to assist in blood clotting. The acute care hospital took before and after pictures of the debrided wound. Review of the wound documentation at the long term care facility revealed no documentation of the excessive bleeding into the calf area that caused the 10 cm by 9 cm. hematoma. The weekly skin check written in the nursing notes documented that there were skin tears to the left lower extremity, but there was no documentation as to color, measurements i.e. depth, length or width, drainage or odor. Nor was there any	F 309		

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F 309	Continued From page 6 documentation that the resident was continually assessed for any internal bleeding after falling and requiring steri strips to a laceration of the left lower extremity. Dressing changes were done to the toes on the left leg daily, but the facility failed to have evidence that the laceration to the left lower leg was assessed or monitored for bleeding or infection. On the transfer documentation sent to the acute care hospital, the only entry concerning the resident's skin condition stated that the resident had "multiple skin problems." There was no documentation of the 10 cm by 9 cm hematoma, that was covered with necrotic tissue, on her left calf area. Cross reference Tag F 281 regarding the facility's failure to monitor the resident in accordance with professional standards of practice. Resident #1 was admitted with diagnoses of peripheral vascular disease, cellulitis, Coumadin therapy, congestive heart failure and decubitus ulcers. All of which would have some relationship to poor extremity circulation and placed the resident at risk of skin breakdown. There was documented evidence that the resident had fragile skin due to her medical condition and her advanced age. The facility failed to ensure that on-going assessments were conducted and that the assessments were documented in the medical record to ensure that Resident #1 maintained her highest practicable physical well-being. Regarding issue B. Resident #1 was admitted on 4/1/05, with a physician order for IV antibiotic therapy due to ulcerated toes on her left foot. On 4/2/05 the	F 309			

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F 309	Continued From page 7 resident heplock infiltrated and the staff were unable to get another line in place to give the IV antibiotics. The order for IV antibiotics was changed to Rocephin 1 GM IM (intermuscular) daily for 7 days. One of the side effects of antibiotic medication is an overgrowth of fungal bacteria in the female peri area called candidiasis (yeast infection). Candidiasis is caused by a fungal bacteria called Candida Albicans. Candida Albicans is ordinarily a part of humans normal gastrointestinal flora, but which becomes pathogenic when there is a disturbance in the balance of flora. One of the causes of this imbalance of gastrointestinal flora is prolonged administration of antibiotics. This condition is not uncommon in the female population when high doses of antibiotic therapy is administered. Resident #1 needed assistance for all of her ADL tasks. She was assisted to the bedside commode and she needed assistance for bathing. Review of the data collection sheets for bathing and showering revealed that the resident had been showered two times from 4/1/05 to 4/16/05. Upon admission to the hospital the ER nurse documented that "the resident's peri area had not been washed for over a month, was red and swollen, had yeast growing and when the RN wiped the peri area the patient began to bleed." The history and physical had documentation that stated "on examination of the groin area, there are diffuse erythematous papular lesions and patch consistent with skin candidiasis." The facility had no documentation that explained why the resident had not been showered the scheduled two times a week. There was not any nursing or CNA documentation that revealed Resident #1 was getting a reddened peri area.	F 309			

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F 309	Continued From page 8 Nor was there any evidence that any of the nursing staff were observing the resident for signs and symptoms of yeast infection caused by her antibiotic use. Review of care plans for Resident #1 revealed no written plans for the adverse effects of antibiotic therapy, showering nor the risk of skin breakdown. When the facility was notified of the lack of monitoring for skin breakdown and the lack of showering of the resident, they did send data that stated that the resident had refused to shower (although this was not documented in the medical record). There was also documentation that stated that there was lack of time, during shifts, to allow for the completion of scheduled showers for Resident #1.	F 309			

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